The Health of New Hampshire's Community Hospital System

A Financial Analysis

Lakes Region General Hospital




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

February 2001

Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

The Department wishes to thank the following individuals and organizations for making this financial analysis possible. First, this project was made possible through a grant from The Robert Wood Johnson Foundation's *Access Project*, directed by Catherine Dunham, Ed.D. Second, Dr. Nancy Kane and her graduate students at the Harvard School of Public Health prepared the financial analysis and narratives. Finally, the Department extends its appreciation to the Chief Financial Officers and Presidents of each New Hampshire hospital for reviewing the standardized financial spreadsheets and financial analysis to ensure their accuracy.

For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

LAKES REGION GENERAL HOSPITAL
LACONIA, NEW HAMPSHIRE
1993 – 1999 FINANCIAL ANALYSIS

Lakes Region General Hospital is a 117-bed acute-care facility in Belknap County [3]. As of 1997, Medicare followed by private insurers represented the largest percentage of payers for inpatient discharges (43 and 38%, respectively)[4].

The hospital and its wholly owned Workers' Compensation Trust are referred to as Lakes Region Hospital Association, and financial data are consolidated with physician practices. Additionally, the Association has an equity investment in a physician hospital organization called Good Health Medical Services of Laconia, LLC.

Summary of Financial Analysis 1993-98
The hospital is financially stable, though in 1997 and 1998, operating profitability was negatively affected by a sharply rising deductible, due in part to an increase in Medicare and a reduction in privately insured payer mix. The bottom line became more dependent on the contribution of investment income. Long-term borrowing increased, while cash balances increased even more. Solvency measures improved over the period. Profitability, liquidity and solvency indicators reflect a stable, sustainable financial situation.

Cash Flow Analysis 1993-98
Over the six-year period, the Association generated most of its cash internally from net income and depreciation (41% and 28% of total cash sources, respectively). These equity sources of cash were augmented by long-term borrowing, which represented 29% of the hospital's cash sources. Long-term debt was issued to turn over existing debt in 1993 and to generate additional capital in 1998.

Almost half of the total cash generated over the period was spent on property, plant and equipment (PP&E). Though this level of investment ($19.8M) was lower than depreciation expense ($23.7M), the average age of plant remained relatively stable and young at 7 years in 1998.

Most of the remaining uses (41%) went to increasing investments in marketable securities; by 1998, two-thirds of them were in board-designated, and one-third in trustee-held, accounts (the latter rose by $10M in 1998 due to a commensurate increase in long-term debt). An additional 4% of the total cash generated ($1.8M) was held in the current cash account.

This pattern of cash sources and uses is healthy and sustainable.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Ratio Analysis 1993-98[5]

Profitability

Profitability was good, though the bottom line became more dependent on nonoperating activities, particularly investment income. A changing payer mix in recent years also affected operating margins.

Prior to 1994, total margins were driven mostly by operating income, which remained stable at 2% until 1997, when the markup of price above cost did not offset the growth in payer discounts (deductible) and resulted in operating losses. The markup adjusted for deductible recovered in 1998 and revenues grew faster than operating expenses, resulting in the recovery of a positive operating margin.

Total margins became more dependent on investment income after 1994. A three-fold increase in investment income between 1994 and 1995 resulted in growth in total margins from 3 to 8%. The level of investment income was relatively stable, with the exception of 1997 when further growth in investment income caused the total margin to increase to 10%. Total margins declined to 6% in 1998.

Liquidity

Liquidity indicators overall are good. The current ratio was relatively stable with the exception of 1997, when it dropped below 2.0, in part due to a large increase in third-party liabilities. At this level (1.76), the hospital's ability to meet its short-term obligations was comparable to the state median.

The days cash on hand measures reveal that liquid resources are strong. Short-term cash resources grew to 43 days of operating cash by 1998. With unrestricted marketable securities (i.e., board-designated investments), the hospital had 240 days of unrestricted cash by 1998.

Trends in working capital management contributed to the growth in the cash account. Collections of patient accounts improved from 77 to 67 days, while the average pay period increased from 33 to 42 days.

Capital Structure

Despite increased borrowing, the hospital's solvency measures improved over the period following growth in profitability and equity in recent years. The equity financing ratio (equity/total unrestricted assets) increased from 39% in 1993 to 48% in 1998.

The hospital's ability to cover its debt improved in recent years with increased profitability, as illustrated by the cash flow to total debt measure. The debt service coverage ratio indicates that the hospital has no problem servicing its debt. The ability to service debt principal and interest payments with cash generated from net income remained strong over the period, even when only cash from operating income was considered.

Charity Care and Community Benefits

Charity care reported as charges forgone represented 2.3 to 3.7% of gross patient service revenues from 1993 to 1998. This amount of charity care met the estimated value of the hospital's tax

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

exemption in 1994 and 1996. With the inclusion of 50% bad debt, this benchmark was met in all years.

The hospital reported additional community benefits in the footnotes to its financial statements amounting to $2.2M between 1994 and 1997. If these amounts are added to free care costs, the hospital also meets its estimated tax value in 1995.

In addition to charity care, the hospital operates a trauma center and offers HIV/AIDS services[1], which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

Patterns of cash flow are largely unchanged from the 1998 analysis, with the exception that non-cash adjustments contributed a larger portion of cash generated (34%, up from 28%), and a lesser portion was generated through long-term debt (24%, down from 29%).

Roughly half of all cash (52%) is used in the investment of property, plant, and equipment (PP&E). Another third of the cash (32%) is used to increase board-designated funds. The remaining 16% was used for the following: 6% to increase working capital; 4% increase in cash reserves; 3% decrease in ONCL; 1% each to increase non-current assets and transfers to affiliates.

1999 Ratio Analysis

Profitability

1999 marked the largest operating loss over the period 1991-1999 (-6%). Non-operating gains were able to offset this amount (the total margin was 3%), but expenses are increasing at a much higher rate (8%) than revenues (1%). A drop in the markup and a jump in contractual adjustments (deductible ratio) appear to be major reasons for the sharp drop in operating profits in 1999.

Liquidity

Indications for liquidity are mixed. The hospital is well able to pay its short-term obligations with and without the addition of board-designated funds (Current Ratios: 2.15 and 5.11 respectively). However, the days in accounts receivable has increased from 67 days in 1998 to 87 days in 1999. This is above the 1999 New Hampshire hospital industry 75th percentile and indicates collection issues. The average pay period has increased from 42.25 days in 1998 to 49.57 days in 1999. Both figures are on the high end (unfavorable) of New Hampshire hospitals. Considering only current unrestricted assets, the hospital has roughly 41 days cash on hand. The cash on hand is 231 days, however, when board-designated funds are included.

Capital Structure

Lakes Region has an equity financing ratio of 0.49 and long-term debt to equity ratio of 0.82. The hospital is more leveraged than most hospitals in New Hampshire, and more leveraged than the national average. In 1999, the hospital was just barely able to meet its debt service coverage with its operating income (Debt service coverage/operating income: 1.01). When all income sources are considered, however, the hospital was able to meet the debt service coverage 2.75 times. Also, the hospital's total cash balances of roughly $44M exceed the $35M in long-term debt as of 1999, so solvency is not compromised by the large 1999 operating loss.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 2.27% of gross patient service revenue. This is the same proportion of contribution as last year. Additionally, the hospital wrote off 3.38% of its GPSR as bad debt.

Summary

Overall, Lakes Region's financial position is still quite healthy. While its profitability from operating income has taken a sharp hit, income from investments has offset the loss placing it at a level just below the national average. The hospital's liquidity looks good, although the collection period is again increasing. Furthermore, while the hospital has more debt than many hospitals in the state, it has demonstrated that it can meet the long-term obligations without difficulty. Although the hospital's financial position still reflects a stable situation, the decline in profitability, if continued, and high level of debt could have adverse effects in the long run.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health